

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39927
STATE FINGER NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1085

S. 300
v. 1-57

566

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clara</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St John's Hospital</u>			Length of stay in 1b <u>2 1/2 Weeks</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CLARENCE</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1888</u>		9. AGE (In years last birthday) <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Diversified Farming</u>		11. BIRTHPLACE (City and state or country) <u>Texas County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Baker</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL-SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Fannie Davis, Clara, Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>obstructive hydrocephalus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>3442.</u>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
21. I attended the deceased from <u>5 Nov 57</u> to <u>7 Nov 57</u> and last saw ^{him} alive on <u>7 Nov 57</u> Death occurred at <u>2:45 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. W. Lawson, M.D.</u>				22b. ADDRESS <u>Med. Ant Bldg</u>		22c. DATE SIGNED <u>11 Nov 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov 8, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wolford Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Texas County, Missouri</u>		
24. FUNERAL DIRECTOR <u>Jewell E. Windle</u>				25. DATE RECD. BY LOCAL REG. <u>11-12-57</u>		26. REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Robert E. Muhlman

Licensed Embalmer No. 4916

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.